

10.10 Recovery House Rules
Park County Resident Application

Date: _____

Name: _____ DOB: _____ Age: _____

SS#: _____ Annual Income: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Work #: _____ Contact #: _____

Race: White___ African American___ Native American___ Hispanic___ Other___

Male___ Female___ Marital Status: Single___ Married___ Separated___ Divorced___

Referred By: _____

Have you completed an alcohol/drug evaluation? _____ If so, when? _____
Where? _____

Date of last alcohol/drug use: _____ Are you currently in treatment? _____

If currently in treatment, complete the attached Release of Information for that facility.

If you are not currently in treatment, have you completed treatment in the past year? _____

If yes, where? _____

If yes, please complete the attached Release of Information for that facility.

Are you currently employed? _____ If so, where? Please list name and address:

If unemployed, are you willing to secure employment? _____

Are you currently on probation? _____

Have you been convicted of any violent or sexual offenses? _____

If so, please explain: _____

Authorization to Release Information and Release from Liability for Background Check
is attached and signed? YES___ NO ___

RETURN APPLICATION TO: Southwest Chemical Dependency Program
PO Box 1587, 430 East Park St.
Livingston, MT 59047
(406) 222-2812; fax (406) 222-4764

If accepted into the Park County Recovery House, I agree to the terms including the waiver of any landlord/tenant rights. I understand that I fully subject myself to the rules of the house as set forth in the Resident Contract.

Signature of Applicant _____ Date _____

Park County Recovery House
Application Attachment

This attachment is to be completed in its entirety by an appropriate professional if the applicant is seeking acceptance to the Park County Recovery House from another treatment setting.

Applicant Name: _____ Date: _____

1. Client's substance use and mental health diagnoses:

2. Medication currently prescribed to the client:

<u>Medication</u>	<u>Dosage</u>	<u>Reason for this medication</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Does the client already have appointments scheduled or contact with other treatment professionals (i.e. psychiatrist, psychologist, physician, therapist, etc.)? If so, please list names and what role they will play in the client's continuing care.

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4. What do you see as the client's assets which will assist his/her success in a recovery house environment?

5. What do you see as the client's liabilities that may hinder or serve as barriers to his/her success in a recovery house environment?

6. Any additional comments?

AUTHORIZATION TO RELEASE INFORMATION AND
RELEASE FROM LIABILITY

To Whom It May Concern:

I, _____, authorize you, **Montana Department of Justice Criminal History Online Public Record Search**, to release and furnish any and all information that you have concerning me, including confidential or privileged information pertaining to my **criminal history**, to the **Southwest Chemical Dependency Program**.

The information requested would assist the **Southwest Chemical Dependency Program** in evaluating my background and personal history.

I hereby release you, your company or organization, and those who supplied you with information of any kind from any liability or damages which may result from furnishing the requested information.

Dated this _____ day of _____, 20____.

Expiration Date: _____

Print Name: _____

Social Security Number: _____

Date of Birth: _____

Signature: _____

Witness' Signature: _____

Date: _____

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**RECOVERY HOUSE
LIVINGSTON
HOUSE RULES**

1. RESIDENTS HAVE TO BE APPROPRIATE FOR PLACEMENT WITH OUTPATIENT OR INTENSIVE OUTPATIENT TREATMENT. RESIDENT MUST ATTEND EVERY SCHEDULED APPOINTMENT DETERMINED BY PRIMARY COUNSELOR AND BE MOTIVATED TO GAIN SOBRIETY AND RECOVERY SKILLS. EACH RESIDENT WILL COMPLETE ALL HOMEWORK ASSIGNMENTS. RESIDENTS WILL BE COURTEOUS OF PEOPLE TRYING TO COMPLETE HOMEWORK.

2. THERE ARE AA/NA MEETINGS EVERYDAY OF THE WEEK, RESIDENTS ARE EXPECTED TO ATTEND AT LEAST FIVE (5) OF THESE MEETINGS WEEKLY. A MINIMUM OF ONE (1) MEETING MUST BE ATTENDED ON THE WEEKEND.

3. NO SMOKING-RESIDENTS MAY SMOKE OUT BACK OF THE HOUSES OR IN THE COURTYARD OF THE APARTMENTS. RESIDENTS MAY NOT STAND IN FRONT OF THE HOUSES OR APARTMENTS AND SMOKE.

4. NO CANDLES ARE ALLOWED IN THE RECOVERY HOUSE, THIS INCLUDES CANDLE WARMERS.

5. NO ALCOHOL, ILLEGAL DRUGS OR UNPRESCRIBED PRESCRIPTION MEDICATION. ALL MEDICATION PRESCRIBED MUST BE DECLARED TO THE PRIMARY COUNSELOR. ANY DETOX MEDICATION WILL BE PRESCRIBED BY A DOCTOR AND HANDLED BY THE STAFF OF THE RECOVERY HOUSE AS DETERMINED BY THE PROGRAM DIRECTOR.

6. NO WEAPONS OF ANY KIND i.e.: GUNS, KNIVES BOWS, ETC. THIS INCLUDES AMMUNITION.

7. EACH RESIDENT WILL PARTICIPATE IN CLEANING, COOKING, YARD WORK, SIDEWALK CARE. EVERY RESIDENT WILL CLEAN UP AFTER THEMSELVES.

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8. EACH RESIDENT WILL PRACTICE FAMILY VALUES AND TREAT EACH OTHER WITH RESPECT AND COURTESY. BICKERING, ARGUING AND FIGHTING WILL ABSOLUTELY NOT BE TOLERATED. ANY CONTROVERSY WILL BE BROUGHT TO THEIR PRIMARY COUNSELOR FOR RESOLUTION. THE SITUATION WILL BE DISCUSSED IN STAFFING AND A RESOLUTION WILL BE MADE. THE RESIDENTS INVOLVED WILL ADHERE TO THE DECISION.

9. RESIDENTS ARE NOT ALLOWED IN OTHER RESIDENTS' ROOMS FOR ANY REASON.

10. IMMEDIATE EXPULSION WILL TAKE PLACE FOR THEFT. IF THEFT OCCURS, EVERY PERSON'S SPACE WILL BE CHECKED.

11. LANDLINE CALLS WILL BE LIMITED TO 10 MINUTES PER CALL. WITHOUT EXCEPTION, CLIENTS WILL ANSWER ALL CALL WAITING CALLS.

12. CURFEW AND SIGN OUT: RESIDENTS ARE REQUIRED TO CALL THE DESIGNATED PERSON EACH TIME THEY LEAVE AND CALL AGAIN UPON RETURNING TO THE HOUSE. CURFEW IS AT 10:00 PM ON WEEKNIGHTS AND 11:00 PM ON FRIDAY AND SATURDAY EVENINGS. A CURFEW OF 10:00 WILL BE ADHERED ON SUNDAY EVENINGS. EACH RESIDENT MUST PROVIDE A PHONE NUMBER FOR CONTACT.

13. A RESIDENT MAY BE ASKED TO LEAVE THE HOME FOR ABUSE OF REASONS LISTED ABOVE.

14. RESIDENT MAY NOT FREQUENT ESTABLISHMENTS THAT SERVE ALCOHOL. IF A RESIDENT WISHES TO DINE AT AN ESTABLISHMENT WITH ALCOHOL IT MUST BE DISCUSSED WITH THE PROGRAM DIRECTOR BEFOREHAND.

15. RESIDENTS ARE DISCOURAGED FROM FORMING NEW INTERPERSONAL/ROMANTIC RELATIONSHIPS. NON-RESIDENTS ARE NOT ALLOWED IN THE RECOVERY HOUSE.

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16. A RESIDENT WILL NOT BE ALLOWED OVERNIGHT STAYS OUT OF THE HOUSE. A RESIDENT MAY DISCUSS A SITUATION WITH THE PROGRAM DIRECTOR I.E. AN AA/NA CAMPOUT, VISITATION WITH A CHILD, ETC. EACH CIRCUMSTANCE WILL BE VIEWED INDIVIDUALLY.

17. RESIDENTS ARE EXPECTED TO ACCOUNT FOR THEIR WHEREABOUTS. PRIOR TO LEAVING THE HOUSE, THE CLIENT WILL CONTACT THE PROGRAM DIRECTOR OR BECKY LANE, RECOVERY HOUSE CARETAKER TO REPORT WHERE THEY ARE GOING AND WHEN THEY WILL RETURN.

18. ACTS OF VIOLENCE OR AGGRESSION OR THAT ARE SEXUAL IN NATURE WILL NOT BE TOLERATED. THE POLICE WILL BE CALLED AND THE RESIDENT WILL BE ASKED TO LEAVE IMMEDIATELY.

19. PERSONAL EFFECTS LEFT AT THE RECOVERY HOUSE WILL BE DISPOSED OF IF NOT CLAIMED WITHIN 30 DAYS OF THE CLIENT'S LAST DAY IN THE RECOVERY HOUSE.

20. RESIDENTS WILL ALLOW SWCDP TO CHECK PERSONAL CELL PHONES AT RANDOM.

21. RESIDENTS WILL SUBMIT TO RANDOM URINALYSIS AND/OR BREATHALYZER TESTS AT ANY TIME.

22. RESIDENTS MUST CONSULT WITH SWCDP PRIOR TO DOCTOR VISITS VIA PHONE OR IN PERSON.

RESIDENT

DATE

SWCDP STAFF

DATE

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